County of Los Angeles

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SACHI A. HAMAI
Interim Chief Executive Officer

April 13, 2015

To: Mayor Michael D. Antonovich
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Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe

From: Sachi A. Hamai
Interim Chief Executive Officer

LEVERAGING THE COUNTY'S HEALTH SYSTEM TO PREVENT CHILD ABUSE AND NEGLECT

Background

In its final report entitled, *The Road to Safety for Our Children*, the Blue Ribbon Commission on Child Protection (BRCCP) made several recommendations related to child safety and health services. The first recommendation called for the County to pair a Public Health Nurse (PHN) with a Children's Social Worker (CSW), when conducting a child abuse or neglect investigation for all children from birth at least until age one. The second recommendation called for the County to refer to the medical hub all detained children, and all other children under age one being investigated by the Department of Children and Family Services (DCFS). While the BRCCP indicated children under the age of one, the County expanded the age group to all children under 24 months of age. The third recommendation called for an assessment of the strengths and weaknesses of the medical hubs.

DHS Medical Hub Augmentation Plan

On January 9, 2015, the Department of Health Services (DHS) submitted a report of its assessment of the County's Medical Hub Clinics (medical hubs). DHS determined that additional resources would be required in order to: provide higher quality of service, reduce wait times, and increase the number of examinations conducted at the medical hubs. DHS recommended allocating $1,998,363 of its existing resources to enhance staffing resources at the six County-run medical hubs.

Joint Visit Conceptual Design by Chief Executive Office

On January 12, 2015, the Chief Executive Office (CEO) issued a report proposing a conceptual design of how PHNs could be paired with CSWs to conduct joint visits. The report also identified various tasks requiring completion and identified resources needed to implement the joint visit initiative. Finally, the CEO report recommended a phased in approach starting with one medical hub (Martin Luther King, Jr. Outpatient Center) and two DCFS Regional Offices (Compton and Vermont Corridor) rather than a simultaneous countywide roll-out.

Board's Motion Regarding Implementation

On January 13, 2015, this Board approved a motion introduced by Supervisor Mark Ridley-Thomas and Supervisor Sheila Kuehl directing the Interim Chief Executive Officer and Directors of DCFS, DHS, Mental Health and Public Health to:

1. Implement the recommendations, per the CEO's report dated January 12, 2015, for the actionable items related to pairing a PHN and a CSW when conducting abuse and neglect investigations for all children under 24 months of age;

2. Report back in 90 days on the milestones, performance outcomes, operational changes and additional board actions, including an update on the medical hub augmentation and its impact on appointment wait times and functionality of the medical hubs;

3. Finalize policy and recommendations regarding the provision of screenings of newly detained children, including coordination with existing initial comprehensive medical exams; and

4. Report back in the CEO's Recommended Fiscal Year 2015-16 Budget with an assessment of budget and operational changes needed to implement the recommendations.

The Office of Child Protection (OCP) submits this implementation plan for Phase I of the joint visit plan in response to the Board's January 13, 2015 motion. The plan is attached as Attachment I and has a July 1, 2015 launch date. The OCP has worked with the CEO, and DCFS, DHS, Public Health, Mental Health, and County Counsel to develop a workable plan. This report identifies milestones, performance outcomes, operational changes, and an update on the medical hub augmentation.

The screening of newly detained children at each medical hub, as opposed to non-detained children subject to an investigation, will be addressed after Phase I of the CSW-PHN Joint Visit Initiative launches. It is important to note, however, that detained children are seen at medical hubs as DCFS policy requires that detained children be seen at a medical hub within certain timeframes. Finally, the CEO will issue a separate report which includes an assessment of budget and operational changes needed to implement the recommendations necessary to implement the CSW-PHN joint visit initiative.

If you have any questions, please contact Fesia Davenport at (213) 974-1186, or by email at fdavenport@ceo.lacounty.gov.

SAH:FD
VD:ljp

Attachment (1)

c: Executive Office, Board of Supervisors
Children and Family Services
County Counsel
Health Services
Mental Health
Public Health

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Executive Summary

The countywide CSW-PHN joint visit initiative will be rolled out in phases. Phase I will involve the Martin Luther King, Jr. Outpatient Medical Center (MLK Hub) and Compton and Vermont Corridor DCFS regional offices and will launch on July 1, 2015. On that date, recently hired DCFS PHNs will begin training and joint visits will commence later in the month. The July 1, 2015 launch date assumes the existence of several material factors identified in the table below:

Factor	Implementation Milestones and Next Steps	Status*
Hub Augmentation and Capacity	• DHS must hire staff to augment hubs placing an emphasis on the MLK Hub	IP
	• MLK Hub will offer expanded hours and ensure sufficient capacity exists to meet the increased demand for medical screenings	R
	• DMH will co-locate staff at the MLK Hub	IP
	• The DHS Nurse Advice Line will be operational	R
Adequate Space	• DMH staff co-located at the MLK hub must have space and equipment	IP
	• MLK hub space must be configured to enable DMH Medi-Cal certification**	IP
Adequate Staff Resources	• Hiring must be completed by all Departments and staff in place	IP
Procedures for Pairing CSW-PHN	• DCFS and DPH must finalize policies and forms necessary to implement operational changes including the PHN Assessment Tool and the joint visit protocol	IP
Operational Changes	• Streamlined PHN referral form must be finalized by DCFS and DHS	IP
	• Changes to e-mHub must be operational to accept the PHN referral form	IP
Training Staff	• Training Units from DCFS and DPH must finalize a joint training plan and curriculum to include: didactic training, hands-on training, and shadowing	IP

*Status: IP – In Progress; R – Ready to Launch; **Important but launch not contingent upon this factor

In addition, data collection metrics and tracking systems are needed to monitor and analyze results from Phase I and inform adjustments required to improve the process in subsequent phases. A preliminary list of metrics to measure safety, operational efficiency and effectiveness, and desired outcomes has been identified, and an electronic tracking system to capture most of this data is under development by DCFS.

The conceptual design of the joint visit initiative recommended that five PHNs be hired to launch Phase I – two for the Compton regional office and three for the Vermont Corridor office. After working closely with the PHN workgroups, uncovering more details about the logistics and timing of the referral process, and working on various staffing solutions, DCFS management recommends that the number of additional PHNs for the Phase I offices be increased as fully explained in Section III of this report. The OCP supports this request. In addition, DCFS has agreed to fund six additional Medical Case Workers, one for each hub, to assist DHS with the current workload at the Medical Hubs with an emphasis on responding to the needs of children and families referred to the hub through this joint visit initiative as fully explained in Section I of this report.

Lessons learned from Phase I will help to make the staffing projections closer to the actual need, and will enable each phase of the roll out to occur quicker than the phase that preceded it.

Phase I Planning Efforts Since January 2015 Board Motion

The OCP has worked closely with DCFS, DHS, DMH, DPH, and the Service Employees International Union (SEIU) representing PHNs and CSWs to ensure that all essential factors are in place before the launch date. The CEO's Office previously established the CSW-PHN Joint Visit Executive Leadership Committee. This committee consisted of executive managers and Directors from DCFS, DHS, DMH, DPH and helped to develop the conceptual design of the joint visit initiative presented in the CEO's January 12, 2015 Board report. The OCP met with the committee on March 3, 2015 to obtain an update on progress made since the Board issued its directive to take all actionable steps to implement the joint visit initiative.

After the Board's January 13, 2015 motion directing the CEO and other involved Departments with implementing all actionable items, DCFS established three implementation workgroups. These workgroups were established to begin the process of converting the joint visit conceptual design into practice. The workgroups are:

CSW-PHN Pairing: This workgroup was established to address all operational issues and identified implementation barriers to the conceptual design.

Policy & Training: This workgroup was established to address all policy and training issues associated with the joint visit initiative. The group is also charged with developing a workable training plan that equips PHNs and CSWs to team with each other during the joint visit, yet maintain an appropriate amount of independence to perform their separate functions.

Data & Measures: This workgroup was established to focus on the type of data needed to capture both operational and programmatic information that will help us determine whether the joint visit model as implemented is effective and supports the desired safety and health related outcomes.

On February 19, 2015, DCFS held a meeting with PHNs and a subsequent meeting with the SEIU management representing the PHNs. During those meetings, PHNs raised a number of questions regarding the joint visit initiative. The OCP has worked with SEIU, DCFS and DPH to prepare solutions and responses to the questions. While answers to some questions remain under consideration, none of the remaining questions pose a barrier to implementation. DCFS and SEIU must hold another meeting with staff to share the responses to the questions and also share the final plan for the Phase I roll-out before implementation. In addition, the OCP met with the workgroups, management from the involved Departments, SEIU Representatives, Nursing Directors from DHS and DPH, and County Counsel on March 10, 17, 20, 24, and 27 to obtain material updates, advice, and legal counsel to support the OCP's coordination of the planning efforts of all involved departments.

To aid understanding, this report provides updates and identifies next steps in the context of the following areas:

I. **Medical Hub Augmentation and Capacity** – This section provides an update on the Medical Hub expansion. This section also focuses on efforts to position the MLK Hub for Phase I of the joint visit initiative.

II. **Co-located Mental Health Services –** This section provides an update on the progress DMH has made in its plan to provide co-located mental health services at the MLK Hub.

III. **Public Health Nurses (PHNs) Staffing** – This section provides an update on the progress DCFS has made in developing a staffing and hiring plan to ensure sufficient resources for the Phase I DCFS regional offices.

IV. **Implementation Concerns and Solutions** – This section provides an update on concerns raised by Public Health Nurses and the solutions developed to address those concerns.

V. **CSW-PHN Joint Visit Policy, Training and Operations** – This section describes the major policy, procedural, and operational changes required to implement the joint visit initiative.

VI. **Measures and Outcomes** – This section describes the metrics to be measured and outcomes we seek to improve as a result of the joint visit initiative.

I. Medical Hub Augmentation and Capacity

Space

Hub space enhancements are in the planning stages at the MLK Hub. For MLK, DHS has determined that the existing Hub space will accommodate the Phase I joint visit initiative for the time being. On February 3, 2015, Supervisor Mark Ridley-Thomas introduced a motion that was approved by the Board to assess the feasibility of relocating the Hub to another MLK campus location. In the Board motion, the location was specified and a new building to accommodate the more collaborative and integrated vision for hub services is currently being planned. The preliminary timeline to construct the new building is approximately two years.

Space enhancements are also in the planning stages at the Harbor-UCLA Hub. At Harbor-UCLA, DHS has been working on a plan to relocate the Hub from two trailers on campus to a larger space. The Harbor Hub staff and hospital leadership are determining the correct clinic layout and working to minimize the structural modifications required to improve the space. DHS is working to propose a funding strategy for these renovations.

Hub enhancements for the Olive View Hub have been completed. Staff at the Olive View Hub moved into their new space in the hospital on January 26, 2015. The Hub now has four exam rooms compared to two previously, as well as more space for co-located DCFS and DMH staff.

Staff

On January 13, 2015, this Board directed the CEO to add 14 new positions to the DHS budget to augment staffing levels at all six DHS medical hubs. CEO has granted DHS hiring authority to fill the positions during the current budget year. The 14 items will be added in DHS' FY 2015-16 Recommended Budget and effective July 1, 2015. Of the 14 items, four are allocated to the MLK Hub as follows. Of these four positions, candidates for two positions (Senior Physician and Nurse Practitioner) have been identified. For the remaining two positions (Financial Services Worker and Medical Case Worker) there is not an existing

list for these items, meaning an exam must be prepared. The timeline for filling these positions is as follows:

- By April 30, 2015 – Exams posted for Medical Case Worker II and Financial Services Worker,
- By May 31, 2015 – Interviews will be completed,
- By June 15, 2015 – Employment offers will be extended, and
- By July 15, 2015 – Appointed candidates will commence work at the hubs.

In order to expedite the hiring for the MLK Hub, by April 10, 2015, DHS will post a transfer opportunity notice for existing Medical Case Workers who may be interested in transferring to the MLK Hub.

In order to support expansion of capacity at the medical hubs and handle the work created by the joint visit initiative, DCFS will supplement the Medical Case Workers at each hub by funding six additional Medical Case Workers – one allocated to each hub. This will result in two Medical Case Workers at the MLK hub. Medical Case Workers will provide care coordination and link children with needed resources to address issues identified by hub providers. For example, Medical Case Workers may follow-up with DCFS, a Regional Center, and/or the child's school for a child with developmental issues. These positions will work closely with the DCFS PHN and CSW to form a case management team, to ensure that services are coordinated and duplication of effort is avoided. The Medical Case Worker will also work to ensure that children and their families receive follow-up appointments and increase the likelihood that parents attend follow-up appointments by contacting the family if an appointment is missed.

Cost: The full cost (i.e. salary and employee benefits) for six Medical Case Worker II items is $416,000. CEO has given DHS authority to hire during this budget year. DHS will request in Final Changes that the six permanent Medical Caseworker II items be added to its FY 2015-16 budget.

In addition, DHS is recruiting to fill three daytime Registered Nurse II positions to staff an advice line as fully described below. No new position has been added to the DHS budget to provide the advice line service.

Operational Changes

Nurse Advice Line

DHS has installed a new telephone line for a Nurse Advice Line at the LAC+USC Medical Center. This telephone line will be staffed twenty-four hours a day, seven days a week by DHS Registered Nurses. In addition to serving caregivers, patients and CSWs, the Nurse Advice Line will be available for DCFS PHNs to contact, if they have a question or are seeking advice to assist them during a joint visit. In instances when a nurse is assisting another caller or is otherwise temporarily unavailable, the PHN will be able to leave a voicemail message and have his or her call returned by the DHS nurse within two hours. The outgoing voicemail message will note that if the caller is unable to wait two hours for a return call, the child should be brought to the closest emergency room or urgent care for evaluation.

Expansion of MLK Hub Hours

DHS has developed a staffing plan that will enable the MLK Hub to extend hours from 5:00 pm to 7:00 pm. Extended hours will be implemented before the Phase I launch date. DHS will continually assess the demand once Phase I begins, and will extend hours of operation to 8:00 pm if necessary. For situations

that require a child to be seen at the Hub after extended hours or on weekends, the child and parent will be referred to LAC+USC Medical Hub.

Streamlined Hub Referral Form

DHS and DCFS are working together to define any changes needed to the existing hub referral form in order to streamline the form for PHN use. They have also developed the technical requirements for a change that will need to be made to the e-mHub system to recognize and accept the streamlined referral form. The work to operationalize these changes is underway and expected to be completed by June 30, 2015.

Next Steps

- Hire all staff ensuring that MLK Hub staff are hired before launch date;
- Operationalize the Nurse Advice Line in advance of the launch date
- Extend hub hours and give notice to all Phase I involved Departments
- Finalize and test the streamlined e-mHub referral form
- Implement changes to the e-mHub system that will enable use of streamlined referral form

II. Co-located Mental Health Services at the MLK Hub

DHS identified the need for children and families served at the Medical Hubs to have onsite access to crisis intervention and a bridge of mental health services, until a family is connected with a mental health provider in the family's community. To address this need at the Medical Hubs and for the Phase I roll-out at the MLK Hub, DHS has worked with DMH to co-locate DMH staff at the hubs including the MLK Hub. The components of co-location include: 1) space and equipment; 2) staff, 3) training, and 4) Medi-Cal certification.

Space

On January 13, 2015 and February 12, 2015, DMH visited LAC+USC Medical Hub facility to learn more about the day to day operation of mental health staff in the medical setting. DMH has been in discussion with DCFS and DHS regarding the needs of co-located mental health staff at the MLK Hub. On February 18, 2015, the Departments discussed the space needs for the co-location of mental health staff at the Medical Hub. After the meeting, DHS provided DMH an approximate number of children and youth referred and general reasons for referral to the medical hub. DMH invited DHS to participate in the interview process of the mental health co-located clinicians. DMH is currently collaborating with DHS on developing a guideline and an agreed upon process for those children and youth who will be receiving mental health services at the hubs.

DMH anticipates being able to bill Medicaid for some of the specialty mental health services its staff will provide to the children and youth referred to the Medical Hub. DMH will work to obtain Medi-Cal certification of the hubs in order to bill for these services. Certification means that the space allows a billing Medi-Cal provider to provide a patient with services and that visit is able to draw down reimbursement from Medicaid. The space must meet the Federal and State Criteria for a space where a

certified provider is able to work. The certification will be done by DMH based on a set of standard elements that must be in the clinical setting. The certification process can take three to six months from the date of the certification request. However, both billable and non-billable services can be provided during the certification process. Panic buttons are required at the point service delivery begins. This is a Department and Union requirement.

Staff

On January 13, 2015, this Board authorized DMH to hire six Psychiatric Social Workers and one supervisor to augment services at the Medical Hubs. On March 2, 2015, DMH hired a Mental Health Clinical Supervisor who will monitor and manage the work of the Psychiatric Social Workers. The recruitment for these social workers is ongoing. Fifteen candidates have been interviewed thus far and DMH intends to make selections and extend offers before June 30, 2015.

Cost: The cost (i.e. salary and employee benefits) of the six Psychiatric Social Worker items and the Mental Health Clinical Supervisors is 825,000. DMH will request in Final Changes that that these permanent items be added to its FY 2015-16 budget. DMH has current authority to hire to fill the six social worker positions. The source of funding, additional costs and potential for revenue offset is discussed in the CEO's report on the Recommended Budget for FY 2015-16.

Training

DMH will train its staff in several areas to ensure that the newly hired Psychiatric Social Workers are prepared to provide effective services. The social workers will be trained in several areas including, screening and assessment, essential DMH data systems, trauma, crisis assessment, documentation, and screening tools. The training dates have yet to be determined but will occur with a sufficient amount of lead time to allow staff at the MLK Hub to absorb the training before the launch date.

Next Steps

- Timely install necessary computers equipment at each hub
- Commence the Medi-Cal certification process
- Hire all staff ensuring that MLK Hub is staffed before launch date
- Train all staff ensuring that MLK Hub staff is trained before launch

III. Public Health Nurses Staffing and Staffing Plan

Staff

Conceptual Methodology

The conceptual design of Phase I identified a need for five additional PHNs to handle the increased number of joint visits - two assigned to the DCFS Compton Office and three assigned to its Vermont Corridor Office. The conceptual design recommended that Emergency Response PHN units be established. This is a sound plan in that this replicates the Emergency Response model used for CSWs.

The estimated need for five additional PHNs was based on data provided by DCFS reflecting the number of referrals for FY 2013-14 involving children under two years of age. The DCFS data reflected the following FY 2013-14 data on referrals involving children under two:

- 6,345 referrals received by the Phase I offices,
- 1,750 of the 6,345 referrals involved a child under two,
- 111 (7%) of the 1,750 referrals involving a child under two received a joint visit, and
- 1,639 (93%) of the 1,750 referrals of a child under two did not receive a joint visit.

The conceptual design recommended five additional PHNs for the Phase I offices to meet the need. Please refer to the CEO's original report dated January 12, 2015 for a detailed analysis of the projected need. The conceptual design does not appear to account for, among other things, the additional 453 referrals received during nights and weekends that are handled by the Emergency Response Command Post for families in the catchment area of the Phase I Offices. For this and other reasons identified below, OCP supports the recommendation that the staffing levels for Phase I be increased.

Determination of Additional Need

The conceptual design called for the creation of an Emergency Response (ER) PHN Unit. The success of this model depends on having a sufficient number of PHNs available day in and day out to conduct visits and to also have time in the office to complete follow-up and link families to services. After analyzing the data and comparing it to the realities of everyday practice with workgroup members, it appears that the initial estimated need for five PHNs seems appropriate as a mathematical proposition, but too conservative to implement a staffing plan.

A review and assessment of the data is the starting point of the staffing analysis. Next, logistical and operational issues must inform a staffing plan – a plan which, in this case, points to a need for additional PHNs. This DCFS staffing plan must address the following:

1) The need for PHNs (like CSWs) to have days when they are not conducting investigations (i.e. being on rotation) allowing them time in the office to conduct follow-up and link families to services;

2) The need to have PHNs available to respond to referrals received after hours and weekends; and

3) The need to have an adequate number of PHNs available during those times where referrals are received simultaneously rather than in a series.

As such, DCFS recommends that the five PHN items approved by the Board be supplemented with nine additional PHNs assigned to the Phase I offices; plus six additional PHNs assigned to the DCFS Emergency Response Command Post (ERCP) operation (to handle nights and weekends); plus two PHN Supervisors to manage the new PHNs in the Phase I Regional offices and ERCP. The OCP supports this recommendation echoing the sentiments contained in the conceptual design – the true need will be unknown until Phase I is implemented and PHNs and CSWs start conducting joint visits. If during implementation it turns out that Phase I Offices are overstaffed, this positions DCFS to roll out Phase II sooner because trained staff can be redirected to Phase II Offices. The revised PHN staffing request is identified below.

Revised PHN Staffing Request

Table 1: PHN Staffing Plan

	Regional Office (Regular Hours)		Weekend/Afterhours	Total
	Compton	Vermont	ERCP	
Total PHN Need	9	7	6	22
PHN Transfers Into Phase I Offices	1	1	0	2
Pre-approved PHN Items	2	3	0	5
New PHN Ask	**6**	**3**	**6**	**15***

* (22 PHNs need - 2 transferred PHNs - 5 Pre-approved new hires = need for 15 additional PHNs)

Table 2: PHN Supervisor Staffing Plan

	Regional Office (Regular Hours)		Weekend/Afterhours	Total
	Compton	Vermont	ERCP	
Total PHNS Need	1	1	3	5
PHNS Transfers Into Phase I Offices	1	1	0	2
Pre-approved PHNS	.50	.50	0	1
New PHNS Ask	n/a	n/a	**2**	**2***

*(5 PHN Supervisors needed – 2 transferred supervisors – 1 pre-approved new hire = need for 2 additional supervisors)

PHNs assigned to ERCP for evenings, nights and weekends will support additional phases of the roll out of the joint visit initiative.

Once Phase I launches, much learning, tracking and adapting will occur. DCFS and DPH will gain a better understanding of what the actual need for PHNs will be. The learning from Phase I will be used to adjust or "true-up" the number of PHNs needed in Phase I offices and the ERCP as well as inform staffing needs for future phases of the joint visit initiative. If Phase I lessons learned reveal that Phase I has been over-resourced, then DCFS will determine the appropriate need and redirect PHN resources to Phase II offices.

Cost:

Previously approved costs – 6 staff, $965,000

- Five PHN and one PHN Supervisor item was previously approved for the Phase I Offices.
- The cost of the salary and benefits for these six items is $965,000.

Additional items requested – 17 staff, $2.75M

- Fifteen additional PHN items and two additional PHN Supervisor items requested.
- The cost of the salary and employee benefits for the 15 additional PHNs is $2.4M and $350k for the two additional PHN Supervisors.

Existing staff – 4 staff, $666k

- DCFS intends to devote four existing staff to the Phase I at a cost of $666,000 for salary and employee benefits.

Total staff devoted to Phase I and costs – 27 staff, $4.4M

- The total number of all staff (existing and new items) devoted to Phase I of the joint visit initiative is 27.

- The total cost of the salary and employee benefits of all staff working on the joint visit initiative for Phase I and the ERCP is $4.4M.

CEO will provide DCFS with ordinance items for this current budget year and for FY 2015-16. DCFS will ask that the permanent items be added to its budget once the total number of needed PHNs and PHN Supervisors is determined.

PHN and PHN Supervisor Staffing Plan

Table 3: Regional Office PHN Staffing Plan

Shift/Hours	Regional Office (Regular Hours)		Total
	Compton	Vermont	
Day (M-T) 7:00 am – 5:30 pm	5	4	**9***
Day (T-F) 7:00 am – 5:30 pm	4	3	**7***
Total			**16**

*** One supervisor assigned to each Phase I Regional Office.**

Table 4: ERCP PHN Staffing Plan

Shift/Hours	Emergency Response Command Post	Total
Day (F-M) 7:00 am – 5:30 pm	2*	**2**
Swing 1 (W-Sat) 4:00 pm – 2:30 am	2*	**2**
Swing 2 (Sat – Tu) 4:00pm – 2:30 am	2*	**2**
Total		**6**

*** One supervisor per shift. Each supervisor will be assigned additional duties to ensure they are fully engaged.**

Hiring Plan and Hiring Timeline

The OCP has been working with DCFS and DPH to coordinate efforts to implement a hiring plan and timeline. DCFS currently does not have a list of eligible PHN candidates from which it can hire PHNs. It takes approximately four months to promulgate a list. DPH has allowed DCFS to use DPH's recently promulgated list in order to expedite the hiring process. DCFS will use the DPH list to invite PHN candidates to apply for the PHN positions allocated to this joint visit initiative. Candidates hired from this list will conduct joint visits and form the PHN – ER units as envisioned in the conceptual design. In order to launch Phase I in July, the additional PHNs should be hired by no later than June 30, 2015. The milestones for the DCFS PHN hiring plan are listed below:

- By April 10, 2015 DCFS issued canvass letter,
- By April 20, 2015 DCFS will begin the interview process,
- By May 10, 2015, DCFS will make final selection of candidates, and
- By June 30, 2015, PHNs are hired and assigned to DCFS regional offices or ERCP.

Next Steps

- Implement PHN hiring plan for PHNs and PHN Supervisors
- Solicit volunteers to serve as Lead Workers to mentor ER PHN Units
- Solicit volunteers to supervise the ER PHN Units

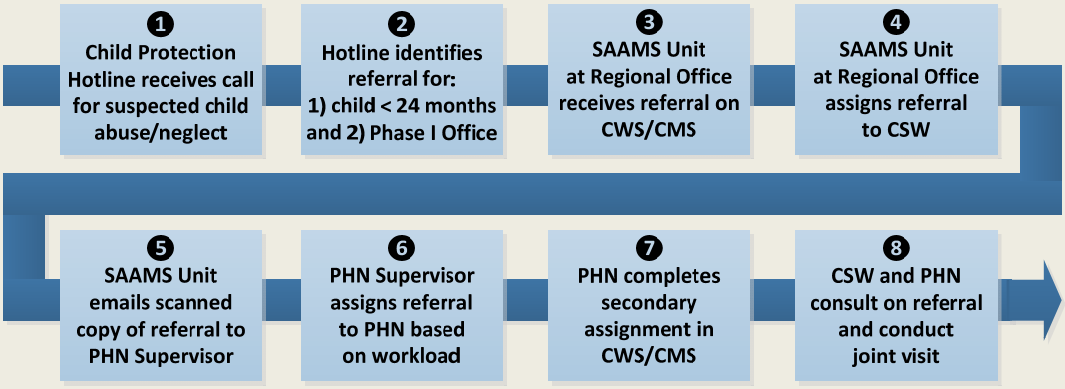
IV. Implementation Concerns and Solutions

The OCP has convened meetings with DCFS, DHS, DPH, and SEIU to work through identified implementation challenges in the following areas: 1) Operational issues associated with pairing PHNs and CSWs; and 2) Policy/Training.

CSW-PHN Pairing Protocol

Figure I on the next page provides a high level overview of a proposed conceptual design for assigning PHNs and CSWs to referrals and then pairing them for a joint visit.

Fig. I: Pairing of CSW and PHN



On February 19, 2015, DCFS held a meeting with PHNs regarding the joint visit initiative and the Phase I roll out. Out of that meeting came various concerns identified by PHN staff and SEIU. The questions that came out of that meeting generally fall into the seven categories identified in Table 5.

Table 5: Issues and Concerns

Issue	Concern
1. Scope of Practice	Ensuring proposed PHN duties under this initiative fall within their scope of practice and thereby are in compliance with the Nurse Practices Act
2. Process and Procedure	Identifying processes in the conceptual design that pose implementation challenges or that will have unintended consequences
3. Policy/Training	Identifying which PHNs will be trained and topics to include in the training
4. Hub Capacity	Assessing whether Hubs will have capacity to handle increased visits
5. Staffing Phase I	Assessing whether 5 additional PHN staff represented a realistic estimate
6. Technological Support	Identifying need for technological support for PHNs in the field conducting joint visits
7. Single Administration	Identifying the County entity appropriate for single administration of the PHN program

DCFS, DPH and DHS have developed solutions to many of the issues and questions posed by staff. For other issues, solutions are being developed. Other issues are outside the scope of this joint visit initiative

as they are more appropriate for bargaining between the County and labor. With respect to all pending issues, the OCP will continue to meet with DCFS, DPH and SEIU to identify solutions. Once solutions or responses have been developed for the identified barriers and concerns, DCFS and DPH will hold another staff meeting with PHNs, PHN Supervisors and CSWs to respond to their questions and share the progress made to date.

Next Steps

- Present the pairing protocol to the DCFS-SEIU labor meeting
- Hold follow-up meeting with PHN and PHN Supervisors to share plans to address issues and share final plan for the Phase I roll–out.

V. Policy and Training

Several policies and forms needed to implement Phase I are currently under development and review. The OCP intends to reconvene the policy workgroups to finalize the policies. Once finalized, the policies must be presented to SEIU representing CSWs before implementation. At or around the same time, DCFS and DPH must also preview the joint visit initiative with stakeholders including: the Dependency courts, attorneys representing parents and children, and community medical providers.

Policy

Work on developing the policies necessary for the joint visit initiative is well underway. The DCFS Policy Unit, in collaboration with DCFS regional staff from the Phase I Offices, and Public Health Nurses drafted a proposed policy document titled, *PHN and CSW Joint Visit on Emergency Response Referrals for Children Under 24 Months of Age*. Once finalized and approved, this FYI will serve as the policy basis of the joint visit initiative. A policy workgroup has been established to vet the document. The workgroup consists of both DCFS and DPH PHNs, SEIU, and the DCFS Policy and Training Unit.

The FYI, among other things, informs staff about the purposes of the joint visit initiative; that Phase I is limited to the Compton and Vermont Corridor Regional Offices; provides direction on what must be done during a joint visit; and outlines the duties and responsibilities of the PHN and the CSW.

PHN Assessment Tool

The PHN Assessment Tool is a form under development that PHNs will use when conducting a joint visit. Recently, the OCP and DCFS sought input on the form from County Counsel and the Nurse Directors from DPH and DHS. Out of this discussion came a recommendation to revise the form to ensure that a PHN's assessment will remain a clinical observation rather than a medical diagnosis. The Nursing Directors have indicated that the proposed PHN Assessment Tool does not call for the PHN to engage in activity that is beyond a PHN's scope of practice.

Next Steps

- Finalize the FYI and present the document to CSWs
- Finalize PHN Assessment Tool
- Communicate plan to stakeholders

Training

A comprehensive training plan is being developed to ensure that Public Health Nurses have the requisite skills to determine whether a child should be referred to the MLK Hub or other appropriate safety related action. The plan is being developed through a collaborative effort between the DCFS and DPH Training units. The Policy/Training Workgroup will re-convene in April to finalize the training plan.

The training plan incorporates a multi-level approach: didactic training, hands-on training, and shadowing. PHNs will be allowed to shadow Emergency Response CSWs in order to gain a better understanding of the type of work they do. Then PHNs will be sent to training. Training modules will take five days to complete and will include lectures, computer-based tutorials, information guides, and simulations. DCFS plans to train all newly hired PHNs, all PHNs in the Phase I offices and all PHN Supervisors in the Phase I offices. Each training cohort will consist of 24 participants. The training curriculum is divided into two components: didactic and practicum.

Table 6: Training Curriculum Components

Didactic	Practicum
▪ Core Practice Model Overview ▪ PHN/CSW Roles and Responsibilities ▪ Emergency Response (ER) Overview & Legal Authority ▪ Procedures for Conducting Joint Visits ▪ Field Safety Considerations ▪ Child Abuse Identification & Reporting Laws ▪ Medical/Health Documentation (including CWS/CMS contact entry)	▪ Scenario simulations where PHNs and CSWs will be able to gain an overall understanding of the joint visit process for the specific target population. ▪ Simulations will enable PHNs and CSWs to get insight into the type of skills that are necessary as well as obtain a perspective on what circumstances can be present during a joint visit.

Next Steps

- DCFS and DPH finalizing training manual and curriculum.
- Develop schedule to allow PHNs to shadow Emergency Response CSWs
- Develop training schedule for newly hired and existing PHNs assigned to Phase I Offices

VI. Measures and Outcomes

To understand the impact that Phase I has on the safety and well-being of children under 24 months, tracking various process and outcome measures is critical. Moreover, the results from Phase I will inform the adjustments required to achieve better results in subsequent phases. A data workgroup has been established. The Data Workgroup was tasked with creating the workflow process to capture data elements to be tracked and monitored during Phase I. Performance will be tracked during implementation of Phase I to ensure that services are provided to children and families; and to inform policy decisions that will impact future phases of the CSW-PHN Joint Visit Initiative as County-wide rollout continues. Most of the data elements are to be documented in CWS/CMS, and monthly activity reports (trends, impact) will be run to measure performance during Phase I.

A preliminary list of data elements that will be tracked and monitored during implementation of Phase I have been identified and categorized into three types of outcomes: (1) process; (2) child welfare; (3) health. These outcomes pertain only to those referrals that received a CSW-PHN pairing during the investigation.

Table 7: Performance and Outcomes Measures

Activity	Measure
Referrals Assigned to CSW and PHN	1. Total number of referrals that paired a CSW and PHN ▪ By time period (traditional business hours; afterhours) ▪ By referral type (Immediate Response, 5-day, etc.) ▪ By child's age (less than 24 months (focus child); siblings over 24 months) ▪ Type of allegation
Joint Visits	2. Total number of visits conducted by PHNs ▪ Number of initial visits that a CSW and PHN conducted together ▪ Number of initial visits conducted separately ▪ Number of joint visits conducted jointly 3. Number of children assessed by PHN (by age)
Hub Referrals by PHN	4. Number of Hub referrals by PHN for medical screening ▪ Number of Hub referral refusals (by parents) 5. Number of children screened at Medical Hub (by age) 6. Number of days that Hub screening occurred after joint CSW-PHN visit
Hub Appointment Management	7. Total number of appointments 8. Number of Hub appointment failures (by parents) ▪ Number of appointments rescheduled – Number of times rescheduled: 1, 2, 3, etc. – Reasons for rescheduling (parent request vs. Hub requests) ▪ Number of children that were not scheduled for an appointment within 72 hours of joint visit and the reasons (parent request vs. Hub unable to accommodate) ▪ Number of families that required (and received) transportation assistance
Child Welfare Related	*The following require a comparison of the baseline with Phase I outcomes by regional office* 9. Number of detentions 10. Impacts on ER referral closure timelines. Information on referrals open > than 30 days ▪ Number of children who required a Hub exam ▪ Number of children who received a Hub exam within 72 hours of joint CSW-PHN visit ▪ Impact of #8 above on referral closures (< 30 days vs. > 30 days) 11. Number of children returning to the system 12. Number of children with recurrence of maltreatment 13. Number of child fatalities, if any
Linkage with Health Care and Supportive Services	14. Number of PHN-generated community referrals 15. Number of children who were referred to services as a result of PHN-generated referrals ▪ Number who received/obtained services ▪ Number who were deemed ineligible by agency ▪ Number who declined services 16. Number of families already connected with Home Visitation and other community-based specialty (resource) services at the time of the referral 17. Number of families with an existing Medical Home (and at time of referral/case closure) ▪ Number with no identified Medical Home at time of referral ▪ Number with private provider as Medical Home at time of referral ▪ Number with DHS as Medical Home at time of referral

More work is required to identify additional measures indicative of health related outcomes for children. The OCP has reached out to DHS and to the Children's Data Network to help identify meaningful health

related measures that can be tracked through this joint visit initiative. As roll-out continues, data collection will improve and the metrics and outcomes initially chosen to be measured will likely change.

Next Steps

- Determine how to track requests for medical records and impact on disposition
- Continue to work on identifying health related outcomes and measures

Conclusion

Since January, much planning and work has taken already place to implement the CSW-PHN joint visit initiative. Each Department is working to implement its hiring plan, and the workgroups continue to meet to finalize policies, procedures and work through other logistical details. The Departments continue to work together to address intra-departmental operational changes. The OCP will provide a pre-implementation report on or before June 15, 2015 to keep this Board apprised of progress being made. The CEO will issue a separate report assessing the budget and operational changes, including personnel and capital improvements needed to implement the recommendations outlined in the Board reports issued by DHS on January 9, 2015 and CEO on January 12, 2015.